SWING BED
SKILLED NURSING OR REHABILITATION SERVICES CERTIFICATION

I certify that _____requires the following post hospital extended care services:

_____
_____
_____

on an inpatient basis because of his/her need for skilled nursing or rehabilitation services on a daily basis for the following medical condition(s):_____
_____

which he/she received inpatient hospital services from_____ to _____. He/She is unable to receive these services on an out-patient or in-home basis for the following reasons:

_____
_____
_____
_____
_____

Attending Physician Signature:_____Date:_____

NOTE:
Recertification (recert.) must be made no later than day 14 of Swing Bed, and then at intervals not exceeding day 30, 60 and 90. The recertification statement may be included in the physician's progress notes. The recertification statement must contain the following:

I. Reasons for continued need for skilled services
II. The estimated period of time the patient will need to remain in Swing Bed
III. Any plans, where appropriate for home care

Recert	Date Recert Needed	Date Recert Completed	Recert Reviewed
14 Day			
30 Day			
60 Day			
90 Day			